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Psychotherapy for pregnant women with psychiatric disorders

Łukasz Müldner-Nieckowski, Katarzyna Cyranka,
Bogna Smiatek-Mazgaj, Michał Mielimąka, Jerzy A. Sobański,
Krzysztof Rutkowski

Chair of Psychotherapy, Jagiellonian University Medical College
Acting head of the Department: dr hab. n. med. Krzysztof Rutkowski

Summary

Pregnancy is a major life change for many women. The related biological changes, especially complications in its course and in the course of delivery, carry a risk of developing a variety of psychological problems and mental disorders. However, their treatment is challenging due to the teratogenic effects of most psychoactive drugs and specific requirements for entering different psychotherapeutic programs. Mental disorders during pregnancy are undoubtedly an important issue for both gynecology and psychiatry. There is still a discussion considering the question whether psychotherapy during pregnancy is safe, although no scientifically valid data contradicting the safety of psychotherapy during pregnancy has been published so far. Together with psychotherapy – as a treatment of choice – clinicians approve some other relatively safe treatment methods for psychiatric disorders in pregnant women. Light therapy, limited pharmacotherapy, ECT are included. The goal of this paper is to review current opinions of clinicians and researches concerning possibilities, indications and outcome of psychological treatments as a way to help pregnant women who suffer from different psychiatric conditions, and also because this subject is not yet present in Polish psychiatric journals.

Key words: pregnancy, psychiatric disorders treatment, psychotherapy

Introduction

Pregnancy is a major life change for many women. The related biological changes, especially complications in its course and in the course of delivery, carry a risk of developing a variety of psychological problems and mental disorders [1]. However, their treatment is challenging due to the teratogenic effects of most psychoactive drugs and specific requirements for entering different psychotherapeutic programs [2, 3]. Psychotherapy unlike other forms of treatment such as pharmacotherapy or

electroconvulsive therapy – ECT (although acceptable in some circumstances) is not associated with a high risk of unwanted side effects in the mother or fetus [4]. Taking this into account, it can be a useful method of help, even if indications for its use result from mild psychopathological syndromes, not meeting all the diagnostic criteria of mental disorders according to the classification of diseases, or they result just from the mother's declared need for support.

There is still a discussion considering the question whether psychotherapy during pregnancy is safe, although no scientifically valid data contradicting the safety of psychotherapy during pregnancy has been published so far. Together with psychotherapy – as a treatment of choice – clinicians approve some other relatively safe treatment methods for psychiatric disorders in pregnant women. Light therapy, limited pharmacotherapy, ECT are included [5].

Aim of the study

The goal of this paper is to review current opinions of clinicians and researches concerning possibilities, indications and outcome of psychological treatments as a way to help pregnant women who suffer from different psychiatric conditions, and also because this subject is not yet present in Polish psychiatric journals [6].

Possibilities of psychotherapy of pregnant women

Pregnant woman frequently experiences a sense of isolation that is often difficult for her to name or communicate. This particular state of mind creates a space to build a fruitful relationship in psychotherapy contact. Openness to the exchange – giving and receiving – not only makes a woman during pregnancy especially prone to produce a therapeutic relationship, but it can also – in the process of psychotherapy – deepen the bond with the patient's partner. Psychotherapy during pregnancy can help the woman to identify with the role of a mother. As researches show, satisfaction with motherhood is linked to the psychological state of a woman during pregnancy, a positive emotional relationship with a child during prenatal development, as well as the mood in the moment of giving birth [7]. Among the technical aspects useful in doing psychotherapy during pregnancy, involving the family is of great importance, as well as paying attention to the interplay between the relationship to the therapist and the fetus. Accordingly, marital intervention is often an important treatment ingredient that amplifies the intra-psychic focus of individual therapy [7].

Psychological support

Many researchers and clinicians underline the benefits of psychological interventions and social support during pregnancy [8]. Besides the strictly psychotherapeutic interventions, limited attention has been given to other forms of support. According to the result of a large Cochrane systematic review, the pregnant woman benefits from intensive, individualized postpartum home visits provided by nurses or midwives and

lay-based telephone support that educate and allow expression of emotional difficulties. The severity and rate of occurrence of postpartum depressive symptomatology is significantly lower in women who have access to these forms of support [9-11]. In a systematic review Lancaster et al. have identified lack of social support as a significant factor that increases the risk of postpartum depression. Out of many types of social support lack of a partner support showed one of the strongest associations in analyses (medium-to-large effect) [12].

Continuation of ongoing psychotherapy

No specific literature on this topic could be found. Considering authors clinical experience, in most cases of long-term psychotherapy the patient's pregnancy is not an indication for suspension or termination of the treatment. On the contrary, the decision to stop the therapy because of pregnancy could turn out to be a strong stressful event, while the contact with the therapist has stabilizing function for woman's psyche. The recommendation to continue the psychotherapy is especially strong for the patients in treatment for personality disorders, psychotic disorders and mood disorders. The continuation of psychotherapeutic process helps to decrease the intensity of symptoms of personality disorders and lowers the risk of relapse in the course of psychotic and mood disorders. On the other hand, if several or most of psychotherapy goals have been achieved (e.g. withdrawal of anxiety symptoms), the pregnancy is not a contraindication for the treatment termination. The decision in such case should be carefully considered and thoroughly discussed with the patient.

Psychotherapy as a medication replacement for relapse prevention

Well-functioning women taking psychiatric medication on long-term basis as relapse prevention in psychotic disorders or mood disorders, according to their doctor's recommendation, decide to stop the treatment quite often when they are planning pregnancy or when they realize that they are already pregnant. In some cases the pregnancy of a woman in a stable relationship, who also has good living conditions, can be a protective factor against potential relapses of mental disorders. Although more often, as it was described above, it constitutes an adaptation challenge for a woman. Thus it is highly recommended to exchange preventive medication with psychotherapy or psychological counselling that would take into account the time of pregnancy and several proceeding months after giving birth. Most of psychoactive drugs should not be applied during breast-feeding, that is why it is vitally important to consider potential profits and losses resulting from withdrawal of the medication or abandoning breast-feeding in the situation when psychotherapy is not sufficiently effective as the only treatment. Good psychological state of the mother is a priority, as she can provide stable conditions for the child's development in the first years of life, which are fundamental for its future mental health [13].

Limitations of psychotherapeutic treatment during pregnancy

Lack of psychotherapy effectiveness during pregnancy and/or intensification of symptoms of psychiatric disorder can be an indication for applying medication or hospitalization [2, 14].

It is important to be careful about the intensity of the emotional experiences during the period of the patient's pregnancy. The attention of pregnant woman is usually directed towards the goals of her motherhood, which makes engagement for exploration of psychological mechanisms less intensive. As a result the therapist during patient's pregnancy usually concentrates more on current events than on the core past experiences or deep emotional patterns, which makes psychotherapy close to counselling, and more distant to the treatment concentrated on the causes of psychological problems [15]. However this is not the rule. St-Andre suggests that pregnancy is a situation favourable for the insight therapy because of more intense psychological experiences: conflicts over dependency needs, narcissistic disturbances, reconciliative themes, and working through losses while giving life [7, 15].

It is usually not recommended to start psychotherapy during pregnancy if the patient who already did experience symptoms of psychological disturbances (i.e. anxiety disorders, eating disorders, personality disorders) and who functions quite well, had postponed the decision to begin the therapy, while hearing the recommendation to do so long before getting pregnant. In such cases the decision to start the treatment is often an expression of a defensive attitude towards the therapy, which requires closer look on motivation and sources of the patient's resistance [16]

According to the authors of this study, psychotherapy oriented towards exploration of difficult memories, traumas and deeper mechanisms of personality structure disorders, should be avoided during pregnancy. Such therapeutic processes require mobilization of the patient, mean considerable effort and often cause symptoms intensification, which can disturb the natural process of preparation to take care of an infant. On the other hand, as described in more detail in further part of this work, pregnancy is a time of particular sensitivity and vulnerability of women to therapeutic interventions [7, 8].

The other restriction is the risk of discontinuing the therapy as a result of possible pregnancy disturbances, confinement period, new responsibilities, time or financial restrictions [14, 15, 17]. In this context, recommendation to plan limitations on the duration or reduction of the intensity of psychotherapy, as well as preparation for differentiation between the objective difficulties and resistance, seem particularly important.

Psychotherapy effectiveness in pregnant women

Currently available research on the effectiveness of psychotherapy during pregnancy is very limited and concentrated around the issue of prevention of postpartum depression. The results from this research show that antenatal psychological interventions may be effective in reducing the risk of developing depression or anxiety in the perinatal period [18-20]. Nevertheless, the question about the type of psychological

intervention that would be associated with greater effectiveness remains unanswered. It was indicated that both interpersonal psychotherapy and parenting education program are almost equally effective in treating antenatal depression [20]. Research by Austin et al. failed to show benefits of brief antenatal cognitive behaviour therapy in reducing risk of developing postpartum depression and anxiety [21]. On the other hand studies suggest that psychological interventions including support, empathy, education, and desensitization are effective in reducing anxiety and depressive symptoms in pregnant women diagnosed with foetal malformations [22]. Cochrane review of psychosocial and psychological interventions for preventing postpartum depression that includes 28 trials (involving almost 17000 woman) indicated that women who receive psychosocial or psychological interventions are significantly less likely to develop postpartum depression in comparison to those receiving standard care. Among psychotherapeutic interventions interpersonal psychotherapy proved to be effective in reducing depressive symptomatology [9]. It was also observed that childbirth education program along with interpersonal therapy applied antenataly are more effective than routine childbirth education classes in: facilitating adjustment to the transition, helping to establish or improve relationships, enhancing perceived social support (also through decreased, more realistic expectations) and enhancing maternal role competence [23].

Much less research attention has been given to the effectiveness of psychotherapy of pregnant woman suffering from various symptoms of emotional crisis. Martin St-Andre writes that "Pregnancy is a life-giving event, but paradoxically a time that can reactivate prior losses" [7]. Presenting case vignettes he argues that conflicts over increased dependency needs, narcissistic disturbances, the relationship with mother and previous losses are important areas of focus in psychotherapy of pregnant woman. Describing those three aspects in detail he points [7] to the following conclusions:

1. Increased dependency needs may lead, in a woman who has struggled to achieve a sense of autonomy, to intense anxiety in fosters regression;
2. Narcissistic disturbance comes to forefront where the gap between maternal ideal ego and present representation of herself appears to be unbridgeable or when a conflict arises between the desire for a baby and the desire to be pregnant;
3. Feelings of envy and rejection towards the foetus may be a manifestation of narcissistic disturbances;
4. Pregnancy may reactivate conflicts of puberty and memories of nurturing experience but at the same time offers an opportunity to differentiate from the mother ("renegotiate separation").

Frequent fears of losing important relationships and the theme of rivalry with the mother play an important role in the time of pregnancy. Therefore reconciliation with the mother is a common focus of psychotherapy of pregnant women. Typical rapid and stable therapeutic alliance can be expected to emerge between the pregnant patient and the therapist. Moreover, pregnant women are exceptionally receptive to psychotherapeutic intervention [8]. It fosters therapeutic efforts and provides opportunity to address and re-establish internalized maternal object. In the state of pregnancy which can be viewed as a process of transformation of identity previously denied and suppressed

thoughts and emotions enter the atrium of consciousness and become available in the psychotherapeutic process [12].

Conclusions

1. The application of psychotherapy during pregnancy is in most cases possible and recommended, although it requires consideration of a new context in the patient's life and adapting its intensity to her current needs.
2. It is an individual issue to what extent supportive or expressive treatment model should be applied. The information about the patient's pregnancy always requires a special attention.
3. Even when pregnant woman seeks help while she has no serious psychiatric symptoms, psychological support or psychotherapy is recommended – in individual, or (less frequently) group setting – because of its prophylactic effectiveness.
4. Occurrence of psychological disturbances connected to pregnancy itself (e.g. depressive reaction) may require psychological support and the possible continuation of the therapeutic relationship in the form of psychotherapy after confinement period, as it is a possibility for prevention of further mental disorder's development.
5. Intensification of previously occurring symptoms (before pregnancy), including mental disorder relapse, is an indication to start psychotherapy or alternatively, if the patient does not qualify for psychotherapy, to introduce biological methods, including limited medication.
6. It is also recommended to continue the therapies started before the pregnancy. The therapist may modify focus of the treatment, change its intensity or review its goals.
7. Introducing psychotherapy treatment during pregnancy is not recommended if the patient who had symptoms of mental disorders before pregnancy and consequently avoided the decision to start psychotherapy is currently functioning relatively well. Psychological support would be recommended though.
8. It is also not recommended to begin psychotherapy in the period of pregnancy if it would be focused on working through difficult memories, psychological traumas or deeper personality structure issues.

References

1. Müldner-Nieckowski Ł, Cyranka K, Smiatek-Mazgaj B, Mielimąka M, Sobański JA, RutkowskiK. *Multiaxial changes in pregnancy: mental health – a review of the literature*. Ginekol Pol. 2014; 85(10): 784-787.
2. Szajer K, Karakuła H, Pawęzka J, Grzywa A, Przywara G, Gut A. *Psychofarmakoterapia zaburzeń lękowych, obsesyjno-kompulsyjnych oraz snu w okresie ciąży i laktacji*. Psychiatr. Pol. 2005; 39(3): 519–526.

3. Casper RC, Fleisher BE, Lee-Ancajas JC, Gilles A, Gaylor E, DeBattista A. et al. *Follow-up of children of depressed mothers exposed or not exposed to antidepressant drugs during pregnancy*. J. Pediatr. 2003; 142: 402–408.
4. Dąbrowski M, Parnowski T. *Analiza kliniczna skuteczności i bezpieczeństwa leczenia elektrowstrząsowego*. Psychiatr. Pol. 2012; 46(3): 345–360.
5. Krzystanek M, Krupka-Matuszczyk I. *Leczenie światłem widzialnym depresji u kobiet w ciąży – studium 3 przypadków*. Psychiatr. Pol. 2006; 40(2): 261–267.
6. Sobański JA. *Współczesne kierunki badawcze w polskiej psychiatrii na podstawie publikacji w Psychiatrii Polskiej w latach 2010–2012. Doniesienie wstępne*. Psychiatr. Pol. 2012; 46(4): 691–707.
7. St-Andre M. *Psychotherapy during pregnancy: opportunities and challenges*. Am. J. Psychother. 1993; 47(4): 572–590.
8. Makara-Studzińska M, Pietrzak A, Lewicka M, Sulima M, Kowalczyk K, Michalak-Stoma A. et al. *Somatic and non-somatic problems connected with psoriasis in pregnancy*. Ginekol Pol. 2013; 84(3): 211–313.
9. Dennis C, Dowswell T. *Psychosocial and psychological interventions for preventing postpartum depression*. Cochrane Database Syst. Rev. 2013; 2: CD001134.
10. Podolska MZ, Majkowicz M, Sipak-Szmigiel O, Ronin-Walknowska E. *Personality profiles of pregnant and postpartum women with symptoms of perinatal depression: the differences of self image in the sphere of psychological needs*. Ginekol Pol. 2009; 80(5): 343–347.
11. Podolska MZ, Majkowicz M, Sipak-Szmigiel O, Ronin-Walknowska E. *Cohabitation as a strong predicting factor of perinatal depression*. Ginekol Pol. 2009; 80(4): 280–284.
12. Lancaster C, Gold K, Flynn H, Yoo H, Marcus SM, Davis MM. *Risk factors for depressive symptoms during pregnancy: a systematic review*. Am. J. Obstet. Gynecol. 2010; 202(1): 5–14.
13. Wajda Z. *Percepcja relacji między rodzicami oraz wzory przywiązania a nasilenie objawów psychopatologicznych u dziewcząt w późnej adolescencji*. Psychiatr. Pol. 2013; 47(5): 853–864.
14. Szajer K, Karakuła H, Pawęzka J, Grzywa A, Przywara G, Gut A. *Psychofarmakoterapia zaburzeń afektywnych w okresie ciąży i laktacji*. Psychiatr. Pol. 2005; 39(3): 509–517.
15. Chrzan-Dętkoś M. *Psychodynamiczne rozumienie macierzyństwa — implikacje dla pracy klinicznej*. Psychoterapia 2010; 1(152): 5–14.
16. Podolska MZ, Majkowicz M, Sipak-Szmigiel O, Ronin-Walknowska E. *Style radzenia sobie w sytuacjach stresowych a Lęk-stan i Lęk-cecha u kobiet z objawami depresji okołoporodowej*. Ginekol Pol. 2009; 80(3): 201–206.
17. Kraśnianin E, Semczuk M, Skret A, Semczuk A. *Satysfakcja z opieki okołoporodowej pacjentek rodzących w Polsce/Rzeszów i w Republice Federalnej Niemiec/Gross-Gerau*. Ginekol Pol. 2013; 84(1): 17–23.
18. Phipps MG, Raker CA, Ware CF, Zlotnick C. *Randomized controlled trial to prevent postpartum depression in adolescent mothers*. Am. J. Obstet. Gynecol. 2013; 208(3): 192–196.
19. Kozinszky Z, Dudas R, Devosa I, Csatordai S, Tóth E, Szabó D. et al. *Can a brief antepartum preventive group intervention help reduce postpartum depressive symptomatology?* Psychother. Psychosom. 2012; 81(2): 98–107.
20. Spinelli M, Endicott J, Leon A, Goetz RR, Kalish RB, Brustman LE. et al. *A controlled clinical treatment trial of interpersonal psychotherapy for depressed pregnant women at 3 New York City sites*. J. Clin. Psychiatry 2013; 74(4): 393–399.

21. Austin M, Frilingos M, Lumley J, Hadzi-Pavlovic D, Roncolato W, Acland S. et al. *Brief antenatal cognitive behaviour therapy group intervention for the-prevention of postnatal depression and anxiety: A randomised controlled trial*. J. Affect. Dis. 2008; 105(1–3): 35–44.
22. Gorayeb RP, Gorayeb R, Berezowski AT, Duarte G. *Effectiveness of psychological intervention for treating symptoms of anxiety and depression among pregnant women diagnosed with fetal malformation*. Int. J. Gynecol. Obstet. 2013; 121(2): 123–126.
23. Gao L, Luo S, Chan S. *Interpersonal psychotherapy-oriented program for Chinese pregnant women: Delivery, content, and personal impact*. Nurs. Health Sci. 2012; 14(3): 318–324.

Address: Katarzyna Cyranka
Chair of Psychotherapy
Jagiellonian University Medical College
31-138 Kraków, Lenartowicza Street 14